Part 8. Other Insurance

This part contains instructions for submitting claims for services provided to members who have other health insurance or Medicare, in addition to MassHealth. To determine if a member has other insurance, you must, among other things, follow the instructions for the Recipient Eligibility Verification System (REVS) in Part 1 of these administrative and billing instructions. MassHealth regulations at 130 CMR 450.316 require providers to make "diligent efforts" to identify and obtain payment from all other liable parties, including insurers. "Diligent efforts" is defined as making every effort possible to identify and obtain payment from all other liable parties, and include, but are not limited to:

- determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider; and

- verifying the member's other health insurance coverage, currently known to MassHealth through REVS on each date of service and at the time of billing.

For additional information about third-party-liability requirements, see 130 CMR 450.316. For more information about submitting retail pharmacy claims for members with other insurance, refer to the *POPS Billing Guide*.

Member Has Other Health Insurance

If the member has other insurance, submit the claim to the other insurance carrier, following the other insurer's billing instructions, before submitting the claim to MassHealth. If the claim is denied for reasons other than a correctable error, or is partially paid by the other insurance carrier, you may submit the claim to MassHealth. For general information about submitting the claim to MassHealth, see Part 3 of these administrative and billing instructions.

If REVS indicates that the member is enrolled with a MassHealth managed care organization (MCO), you must obtain authorization from the MCO for any services that are covered by the MCO before providing services. Unauthorized services that are denied by the MCO will not be paid by MassHealth.

For Electronic Claims

Submit the claim according to the HIPAA 837 Coordination of Benefits (COB) requirements. Include all applicable information about the other insurance in the transaction, including payments, noncovered charges, copayments, and deductibles, as outlined in the MassHealth companion guides. The companion guides are available for download from the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

For Paper Claims

Follow the instructions below.

1. Attach to the claim form a photocopy of the other insurance carrier's notice of final disposition. The dates of service, provider name, and patient's name on the notice of disposition must correspond to the information on the MassHealth claim form.

2. If the carrier's notice of final disposition, explanation of benefits (EOB), notice of rejection, or some other explanation on the carrier's letterhead does not itemize payment for each service provided or reduces payment by a nonitemized deductible amount, estimate the portion of the total benefit amount that was paid for each service on that notice.

3. Enter in the Other Paid Amount field of the MassHealth claim form the amount that was paid by the other insurance carrier for each service. The other paid amount must include the contractual adjustment from the commercial carrier. The total for all the lines in the Other Paid Amount fields must equal the total benefit amount on the notice of final disposition, including the contractual amount.

   Exception: For services billed on the UB92 claim form to MassHealth, enter the total amount paid by the other insurance in Item 54.

   Exception: For dental services billed on the ADA Claim Form, check the Yes box in Field 4 of the ADA Claim Form. Ensure that the payments on the EOB are itemized. If payment is not itemized by the insurer, annotate the EOB to reflect the estimated portion of the total benefit amount that was paid for each service on that notice. Enter the total amount paid in Field 35 (Remarks) of the ADA Claim Form. This amount must equal to total amount shown on the EOB.

Updating Other Insurance Information

If you are aware that the information shown on REVS about a member's health insurance has changed, send appropriate documentation to MassHealth verifying the coverage change to ensure the member's file is updated to reflect current information. Acceptable documentation includes an EOB, a letter from an employer, or a copy of the health insurance card for any new insurance.

When submitting documentation to MassHealth to verify a change in a member's health insurance coverage, complete and submit a Third Party Liability Indicator (TPLI) form to the address listed in Appendix A of your provider manual. This form is available on the Web at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library, then on MassHealth Provider Forms. Also see Appendix A of your MassHealth provider manual for information about requesting supplies of this form.

Send the TPLI form with appropriate documentation, as stated above, showing the correct information, a cover letter explaining the discrepancy, and any other supporting documentation. Include the 10-character MassHealth member ID number. Until you receive notification from MassHealth that the

member's file has been updated, you must continue to attach a copy of the EOB to all claims submitted for this member.

MassHealth Members Enrolled in Medicare Parts A and B

If the member has Medicare Part A or B, submit the claim to Medicare. If the intermediary is a Massachusetts Medicare fiscal intermediary, and Medicare makes a payment or applies the charge to the deductible, any remaining amounts are automatically forwarded to MassHealth for processing through the crossover claim system. If the intermediary is not a Massachusetts Medicare fiscal intermediary, see Resolving a Medicare/MassHealth Crossover Claim beginning on page 5.8-4 of these instructions. Be sure to enter the 10-character MassHealth member identification number on the Medicare claim in order for the claim to crossover automatically to MassHealth. Your Medicare provider number must also be on file with MassHealth for the claims to crossover automatically to MassHealth.

Crossover Claims

After Medicare has made a payment or applied the charge to the deductible, MassHealth processes its portion of the claim as a crossover claim. For MassHealth-covered services, MassHealth pays the lower of the member deductible and/or coinsurance or the difference between the Medicare payment and the MassHealth allowable amount. The total payment from Medicare and MassHealth will be no greater than the MassHealth-allowable amount. You will receive an Explanation of Medicare Benefits (EOMB) from Medicare and a Medicare/MassHealth crossover remittance advice from MassHealth, indicating the disposition of the claim processed by each agency.

When Service Is Not Covered by Medicare

If the service is not covered by Medicare, the claim will not cross over to MassHealth. However, you may submit a MassHealth claim for your charges after you have received an EOMB indicating that the claim was denied by Medicare. Submit an 837 Coordination of Benefits (COB) electronic claim, or attach a photocopy of the EOMB to the MassHealth paper claim form. For information about completing the appropriate MassHealth paper claim form, see Part 3 of these administrative and billing instructions. Payment will be based on the MassHealth-allowable amount.

Note about Exhaustion of Medicare Part A Benefits: If the Medicare Part A benefits are exhausted for a MassHealth member, MassHealth will accept the most recent letter stating that benefits are exhausted, an explanation of benefits (EOB) with the benefits exhausted remark code, or the Medicare notice of noncoverage. MassHealth accepts screen prints of the Common Working Files (CWF) with a cover sheet and drop-down version of the electronic Medicare EOB. Due to variations in the electronic Medicare EOB, MassHealth must review electronic formats to verify that each CWF printout has all necessary information. For those providers whose CWF has not yet been approved, please send claims with a CWF printout to the address listed in the Third Party Liability section of Appendix A.

Send all other claims to the appropriate address listed in Appendix A of your MassHealth provider manual.

Member Has Medicare and Another Insurance (in Addition to MassHealth)

If the member has coverage from both Medicare and another insurance company, follow the instructions below.

1. Submit the claim to the appropriate intermediaries and carriers.

2. Once you have received an EOB from both carriers, you may submit the claim to MassHealth. MassHealth will not pay for the service unless the service is covered by Medicare, but the total payment you have received from both Medicare and the other insurance carrier is less than the MassHealth allowable amount.

   Note: If the member has other health insurance in addition to Medicare and MassHealth, the claim will not automatically crossover to MassHealth. See Resolving a Medicare/MassHealth Crossover Claim.

3. If the service is not covered by Medicare and the total payment you have received from the other insurance company is less than the MassHealth-allowable amount, you may submit the claim to MassHealth. The claim may be submitted to MassHealth electronically following the requirements for COB billing for the 837 transaction.

   For information about completing the MassHealth paper claim form, see Part 3 of the administrative and billing instructions. Attach a photocopy of the EOMB indicating that the claim was denied by Medicare and a photocopy of the EOB from the other insurance company to the MassHealth claim form.

Resolving Medicare/MassHealth Crossover Claim

Suspended Claims

If a claim is suspended on a MassHealth Crossover Claim Remittance Advice, no action is required. The error code on the remittance advice will explain why the claim is suspended. This claim will appear on a later remittance advice as either paid or denied.

Submitting Crossover Claims Directly to MassHealth

You may submit a crossover claim directly to MassHealth when:

- 60 days have passed since you received Medicare payment;
- you have received notice that Medicare applied the charge to the deductible, and the claim has not appeared on a MassHealth crossover remittance advice; or
- the member has other insurance in addition to Medicare and MassHealth.

Electronic Claims

You may submit the claim to MassHealth electronically following the requirements for COB billing for the 837 transaction.

Paper Claims

To submit crossover claims on paper, follow the steps below.

1. Submit a separate, legible photocopy of the EOMB for each Medicare claim.
2. On the EOMB, circle the Medicare payment information that you are submitting to MassHealth.
3. Print the 10-character MassHealth member identification (ID) number in the lower-right corner of the EOMB.
4. Your unique Medicare pay-to provider number must be on your MassHealth provider file in order for your claims to process, either electronically or on paper. The Medicare pay-to provider number should not be cut off, crossed out, or written over with a different Medicare provider number. If your Medicare provider number is not on the MassHealth provider file, the claims will not appear on a MassHealth crossover remittance advice. In order to update your Medicare/MassHealth provider file, contact MassHealth Customer Services Enrollment and Credentialing at the appropriate address listed in Appendix A of the MassHealth Provider Manual.

For Medicare B Services

- Attach a legible copy of the original Medicare 1500 claim form or a facsimile of the claim form if you submit claims to the Medicare intermediary electronically. Be sure the Medicare Type of Service (TOS) code is entered in Item 24C of the Medicare 1500 form.
- If the member also has other insurance, attach a copy of the EOB from the other insurer.
- If the claim is for an abortion, sterilization, or hysterectomy, attach the appropriate MassHealth form.
- Send this information to the appropriate address listed in Appendix A of your MassHealth provider manual.

For Medicare Part A Services

Submit only a copy of the Medicare remittance advice. Print the member ID in the lower right corner of the remittance advice. If other insurance is also present, attach a copy of the EOB from the other insurer, and circle the appropriate information on both.

Adjusting a Medicare/MassHealth Crossover Claim

If you are requesting an adjustment to a crossover claim that has been paid incorrectly by MassHealth, or has been adjusted by Medicare, take the following steps for resolution.

Electronic Claims

The claim adjustment may be submitted to MassHealth electronically following the requirements for COB billing and for the 837 adjust/void transaction.

Paper Claims

To submit crossover claim adjustments on paper, follow the steps below.

1. Submit a legible copy of the original EOMB.
2. Submit a legible copy of the adjusted EOMB, if applicable. Circle all the applicable information on each of the EOMBs, and enter the 10-character MassHealth member identification number on in the lower-right corner of each EOMB.

For Medicare Part B Services

- Submit a legible copy of the original Medicare Part B claim form (HCFA 1500 or HCFA 1490.)
- Submit a legible copy of the MassHealth crossover remittance advice on which the claim was originally paid, if applicable. Circle all applicable member information.
- Mail the completed form along with any required supporting documentation, including the reason for the adjustment, to the appropriate address listed in Appendix A of your MassHealth provider manual.
- If your claim has been adjusted by Medicare, but MassHealth has not yet made an initial payment, follow steps (1) through (2) only and send to the appropriate address listed in Appendix A of your MassHealth provider manual.

For Medicare Part A Services

Submit a legible copy of the original Medicare remittance advice, the adjusted Medicare remittance advice, if applicable, and a copy of the MassHealth remittance advice, if applicable.